								Т
IPDR6702	01/22/2006		TDDS	NORTH CAROLINA CHECKWRITE SUMMARY REPORT		PAGE:	1	
NOW DITTO	01/22/2000			ECKWRITE DATE: 01/26/2006				•
				FINANCIAL PAYER: NCDMH				
								$\perp \equiv$
PROVIDER		HIGH DENIAL	NUMBER OF		TNC		TOTAL	TOTAL
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	TOTAL DENIALS	FINALIZED	CLAIMS
	THOVEDER WELL				Dantillo	DINTILLO	111111111111111111111111111111111111111	111111
3404901	SMOKY MOUNTAINM	8599	16	DETAIL NOT COVERED BY COMBINAT				
	H/DD/SAS			ION OF RECIPIENT, PROVIDER AND				ļ
				BENEFIT PACKAGE.				-
		0	0			16	16	
3404904	WESTERN HIGHLAN	0	0	*** NO DATA TO REPORT ***				ļ
	DS LME							
		0	0		(0	0	C
3404910		8505	1985	CLAIM DENIED DUE TO INSUFFICIE				
3404310	PATHWAYS	6303	1903	NT BUDGET				-
								•
		8800	77	FURTHER PROCESSING NECESSARY,	1	. 2235	3211	968
				PLEASE CHECK FOR CLAIM ON FUTURE RA'S.		1	+	-
						1	 	
	1	8534	54	SERVICE FACILITY LOCATION IS N			†	
				OT A VALID IPRS ATTENDING				
				PROVIDER. PLEASE VERIFY THE F				\bot
3404912	CAMANDA COMMINA	11	15	CLIENT NOT ELIGIBLE ON SERVICE		1	+	1
	CATAWBA COUNTYM ENTAL HEALT			DATE			 	+
							†	
	_	8931	14	AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.	14	39	340	301
				RVICES IN IPRS.				-
								-
		21	5	DUPLICATE OF CLAIM-SYSTEM				
								ļ
3404913	MECKLENBURG COM	8599	9	DETAIL NOT COVERED BY COMBINAT				-
	ENTAL HEALT			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		11	7	CLIENT NOT ELIGIBLE ON SERVICE DATE		21	71	5.0
				5442				-
		8931	4	AMTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				ļ
								-
3404916	CROSSROADS BEHA	8535	6	SERVICE FACILITY LOCATION WAS				-
	VIORAL HEAL			NOT INCLUDED IN YOUR 837.				
				PLEASE RESUBMIT YOUR CLAIM WIT				
		0	0					
	+		~	+		6	6	H
	1						†	
3404917	CENTERPOINT HUM	8599	1957	DETAIL NOT COVERED BY COMBINAT				
	AN SERVICES			ION OF RECIPIENT, PROVIDER AND				<u> </u>
				BENEFIT PACKAGE.		1	+	-
		21	799	DUPLICATE OF CLAIM-SYSTEM	389	4515	8859	4344
					30.	.313		
_								
		11	363	CLIENT NOT ELIGIBLE ON SERVICE		-		<u> </u>
		11	363	DATE		-	 	1
				+			 	†
3404918	ROCKINGHAM CO M	0	0	*** NO DATA TO REPORT ***				\bot
	ENTAL HEALT						-	1
							 	
		0	0		(0	0	
2404010	1	9500	27	DETAIL NOT COURDED BY COMPANY				\bot
3404919	GUILFORD CO MEN	8599	27	DETAIL NOT COVERED BY COMBINAT ION OF RECIPIENT, PROVIDER AND			+	-
	TAL HEALTHC			BENEFIT PACKAGE.			 	
		8931	25	AMTNC INELIGIBLE TO RECEIVE SE	33	105	1220	1115
				RVICES IN IPRS.				1
						1	+	-
		8518	17	CLAIM DENIED, SUBMITTED BEYOND			 	
		+		FILING TIMELIMIT. PRIOR			+	1
				FISCAL YEAR DOS (JULY 1 - JUNE				

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404920	ALAMANCE CASWEL	8505	3706	CLAIM DENIED DUE TO INSUFFICIE				
	L AREA MH D			NT BUDGET				
		8599	70	DETAIL NOT COVERED BY COMBINAT	21	3962	5162	1200
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		5404	44	SEVERE DUPLICATE: SAME ATTD PR				
				OV/PCODE/TOS/DOS/MOD				
3404921	ORANGE PERSON C	8505	9810	CLAIM DENIED DUE TO INSUFFICIE				
	HATHAM AREA			NT BUDGET				
		8800	187	FURTHER PROCESSING NECESSARY,	12	10621	13917	3296
				PLEASE CHECK FOR CLAIM ON				
				FUTURE RA'S.				
		8599	130	DETAIL NOT COVERED BY COMBINAT				
		1		ION OF RECIPIENT, PROVIDER AND				
		1		BENEFIT PACKAGE.				
		1						
3404922	THE DURHAM CENT	8535	17792	SERVICE FACILITY LOCATION WAS				
	ER	1		NOT INCLUDED IN YOUR 837.				
		1		PLEASE RESUBMIT YOUR CLAIM WIT				
		1						
		8329	96	CLAIM DENIED ATTENDING PROVIDE	n	17928	18013	85
	1	1		R CANNOT BE THE SAME AS		2.520		0.0
		-		THE LMA				
		-						
		21	24	DUPLICATE OF CLAIM-SYSTEM				
		+						
		+						
		+						
3404923	FIVE COUNTY MH	79	145	THIS SERVICE IS NOT PAYABLE TO				
		+		YOUR SUBMITTED BILLING				
		+		PROVIDER TYPE AND SPECIALTY IN				
		+						
		11	68	CLIENT NOT ELIGIBLE ON SERVICE	1	317	1466	1149
		+		DATE	_	317	1400	2270
		+						
		-						
		8599	42	DETAIL NOT COVERED BY COMBINAT				
		-		ION OF RECIPIENT, PROVIDER AND				
		+		BENEFIT PACKAGE.				
		+						
3404925	SANDHILLS CENTE	8599	609	DETAIL NOT COVERED BY COMBINAT				
	R FOR MH/DD	+		ION OF RECIPIENT, PROVIDER AND				
	R FOR MR/DD	+		BENEFIT PACKAGE.				
	+	+						
	+	8505	365	CLAIM DENIED DUE TO INSUFFICIE		1425	5070	2642
	+			NT BUDGET	61	1435	5078	3643
	+	+			 	+		
	+	+			 	+		
	+	120	64	CLIENT ID NUMBER MISSING OR IN	 	+		
	+	+	1.	VALID. ENTER CID AND SUBMIT	 	+		
	+	+		AS A NEW CLAIM	 	+		
	+	+			 	+		-
3404926	SOUTHEASTERN RE	11	366	CLIENT NOT ELIGIBLE ON SERVICE	1	1		
	G MENTAL HL	+	1	DATE	1	1		
	G MENIAL DL	+			 	+		
	+	+						
	+	10	0		H .			
	+	+			- 0	366	372	6
	+	+			—	1		
3404927	OUMBROTAND CO	8505	1020	CLAIM DENIED DUE TO INSUFFICIE	 	+		
	CUMBERLAND CO M		-320	NT BUDGET	—	1		
	HC	+		=-	—	1		
	+	+			—	1		
	+	8599	75	DETAIL NOT COVERED BY COMBINAT	—			
	1			ION OF RECIPIENT, PROVIDER AND	0	1137	2001	864
				BENEFIT PACKAGE.	 	 		-
			1	DAMES A FROMUE.	1			-
		+						0
		23	1.4	SERVICE DECHIDES DRICH ADDROVA				
		23	14	SERVICE REQUIRES PRIOR APPROVA				
		23	14	SERVICE REQUIRES PRIOR APPROVA L				
		23	14	SERVICE REQUIRES PRIOR APPROVA L				
2404000		23	14	L				
3404929	LEE HARNETT MH/	23	14	SERVICE REQUIRES PRIOR APPROVA L NO DATA TO REPORT				
3404929	LEE HARNETT MH/	23	0	L				
3404929		23	0	L				
3404929		23	0	L				
3404929		0	0	L	0	0	0	0
3404929		0	0	L	0	0	0	C

							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404930		8505	86	CLAIM DENIED DUE TO INSUFFICIE				
3404550	JOHNSTON COUNTY MNTL HLTHC	0303	00	NT BUDGET				
	MNIL BLIBC							
		8800	21	FURTHER PROCESSING NECESSARY,	5	113	125	12
				PLEASE CHECK FOR CLAIM ON				
				FUTURE RA'S.				
		8935	4	ASTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.				
				RVICES IN IFRS.				
3404931	WAKE CO HUM SVC	8599	71	DETAIL NOT COVERED BY COMBINAT				
	BILLING OF			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		21	46	DUPLICATE OF CLAIM-SYSTEM	23	177	1639	1462
		0021	19	AMENIC INDITICIDE TO DECESSE OF				
		8931	1.0	AMTNC INELIGIBLE TO RECEIVE SE RVICES IN IPRS.	-	-		
				EVICED IN LENG.	-	-		
		1			 	 		
3404933	SOUTHEASTERN CT	8599	1836	DETAIL NOT COVERED BY COMBINAT	 	 		
	R FOR MH/DD			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.	1			
		8329	502	CLAIM DENIED ATTENDING PROVIDE	103	2824	4512	1688
				R CANNOT BE THE SAME AS				
				THE LMA				
		79	238	THIS SERVICE IS NOT PAYABLE TO				
				YOUR SUBMITTED BILLING PROVIDER TYPE AND SPECIALTY IN				
				PROVIDER TIPE AND SPECIALIT IN				
3404934	ONOT ON CARMEDEM	11	126	CLIENT NOT ELIGIBLE ON SERVICE				
	ONSLOW CARTERET BEHAV HEAL			DATE				
	DERAY REAL							
		8599	112	DETAIL NOT COVERED BY COMBINAT	0	440	1590	1150
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		21	39	DUPLICATE OF CLAIM-SYSTEM				
3404935	MANAGE OF MENERAL	0	0	*** NO DATA TO REPORT ***				
	WAYNE CO MENTAL	-						
	HEALTH CTR							
					<u> </u>			
		0	0		0	0	0	C
3404936	WILSON-GREENE M	8599	25	DETAIL NOT COVERED BY COMBINAT				
	ENTAL HEALT	1		ION OF RECIPIENT, PROVIDER AND	ļ	ļ		
				BENEFIT PACKAGE.				
		8931	15	AMTNC INELIGIBLE TO RECEIVE SE				4.77
				RVICES IN IPRS.	17	47	1766	1719
		+		447 44.456	 	 		
		1		1	 	 		
		8935	2	ASTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.	1			
3404937	EDGECOMBE NASH	8518	394	CLAIM DENIED, SUBMITTED BEYOND				
	MNTL HLTH C			FILING TIMELIMIT. PRIOR				
				FISCAL YEAR DOS (JULY 1 - JUNE				
		21	107	DUDITONTE OF OTRIM_CVCTPM				
	+	21	107	DUPLICATE OF CLAIM-SYSTEM	0	574	7427	6853
		1		<u> </u>	-	-		
		+			 	 		
	+	8599	40	DETAIL NOT COVERED BY COMBINAT	 	 		
				A Company of the Comp				i
				ION OF RECIPIENT, PROVIDER AND				
				ION OF RECIPIENT, PROVIDER AND BENEFIT PACKAGE.				

PROVIDER		HTOH DENIES	NUMBER OF			ļ	TOTAL	TOTAL
		HIGH DENIAL	NUMBER OF	DECCRIPTION	TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404938	HOPM DDA DAHRDO	0	0	*** NO DATA TO REPORT ***				
	VGFW DBA RIVERS TONE COUNSE		-					
	TONE COUNCE							
		0	0		0	0	0	(
3404939	NEUSE MENTAL HE	8599	2	DETAIL NOT COVERED BY COMBINAT				
	ALTH CENTER			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		0	0				400	404
			-				488	486
3404941	PITT CO MH/DD/S	8599	40	DETAIL NOT COVERED BY COMBINAT				
	AS CENTER			ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		27	31	DIAGNOSIS CODE MISSING OR INVA	0	77	353	276
				LID. VERIFY AND ENTER THE				
				CORRECT DIAGNOSIS CODE AND SUB				
		41.00	4	VOLUMENT AMERICAN TO A DITION A				
		4102	-	YOU ARE ATTEMPTING TO ADJUST A CLAIM THAT IS EITHER NOT		 		-
			+	FOUND ON OUR FILE OR IS NOT FO		 		
			+			 		
3404942	ROANOKE CHOWANH	79	20	THIS SERVICE IS NOT PAYABLE TO		 		
	UMAN SERVIC		1	YOUR SUBMITTED BILLING				
	·			PROVIDER TYPE AND SPECIALTY IN				
		8931	5	AMTNC INELIGIBLE TO RECEIVE SE	8	34	791	757
				RVICES IN IPRS.				
		191	3	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
3404943	ALBEMARLE MENTA	79	45	THIS SERVICE IS NOT PAYABLE TO				
	L HEALTH CE			YOUR SUBMITTED BILLING				
	E READIN CE			PROVIDER TYPE AND SPECIALTY IN				
		8599	25	DETAIL NOT COVERED BY COMBINAT	24	130	899	769
				ION OF RECIPIENT, PROVIDER AND				
				BENEFIT PACKAGE.				
		8931	13	AMTNC INELIGIBLE TO RECEIVE SE				
				RVICES IN IPRS.				
3404944	DA CARDOTANAD IIIMA	79	504	THIS SERVICE IS NOT PAYABLE TO				
	EASTPOINTE HUMA N SERVICES			YOUR SUBMITTED BILLING				
	N SERVICES			PROVIDER TYPE AND SPECIALTY IN				
		8599	282	DETAIL NOT COVERED BY COMBINAT	22	1077	2140	1063
				ION OF RECIPIENT, PROVIDER AND	1			
				BENEFIT PACKAGE.				
		11	73	CLIENT NOT ELIGIBLE ON SERVICE				
			1	DATE		ļ		
			1			-		
3404946		21	1113	DUPLICATE OF CLAIM-SYSTEM		1		
240424D	FOOTHILLS AREAM	***	****	DOLLICATE OF CHAIN-SISIEM	-	 		
	ENTAL HEALT		+	+	1	+		
	1		+	+	1	+		
		8622	88	60 RESIDENTIAL LEVEL II TREATM	91	1488	3384	1896
	1		1	ENT RECEIVED, PA IS REQUIRED	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1400	2304	2090
				FOR ADDITIONAL SERVICE.				
		191	82	CLIENT ID NUMBER DOES NOT MATC				
				H PATIENT NAME				
240405-		2525						
3404957	TIDELAND MENTAL	8536	9	ATTENDING PROVIDER TYPE AND SP ECIALTY COMBINATION IS NOT		1		
	HEALTH CTR		1	ECIALTY COMBINATION IS NOT VALID FOR SUBMITTED BILLING PR		1		
			+	VIDED FOR SUBMITTED BIBLING PR		 		-
	1	8599	5	DETAIL NOT COVERED BY COMBINAT		24	657	
			1	ION OF RECIPIENT, PROVIDER AND	4	24	657	633
			1	BENEFIT PACKAGE.		 		
			+	+	 	 		
		1	l-	THIS SERVICE IS NOT PAYABLE TO	1			†
		79	3					
		79	5	YOUR SUBMITTED BILLING				
		79	3					

	1	1	1	T		1		1
							TOTAL	TOTAL
PROVIDER		HIGH DENIAL	NUMBER OF		TNC	TOTAL	CLAIMS	CLAIMS
NUMBER	PROVIDER NAME	EOBS	DENIALS	DESCRIPTION	DENIALS	DENIALS	FINALIZED	PAID
3404979	NEW RIVER AREAM	11	191	CLIENT NOT ELIGIBLE ON SERVICE				
	H/DD/SA PRO			DATE				
		8505	134	CLAIM DENIED DUE TO INSUFFICIE	0	406	498	92
				NT BUDGET				
		8800	77	FURTHER PROCESSING NECESSARY,				
				PLEASE CHECK FOR CLAIM ON				
				FUTURE RA'S.				